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RISE OF THE HOSPITAL IDEA*

E. H. L. Corwin

Even if I were an historian and had more than a superficial knowledge about the evolution of hospitals and its literature, I could not do justice to the subject as comprised in the title, within the compass of time allotted to the presentation of this discourse. The subject presents a challenge to those who have the leisure and a penchant for historical inquiry, the necessary insight and discernment, and the ability to write well. With the exception of several monographs of excellence, among which particular mention should be made of "The Romance of the British Voluntary Hospital Movement" by Evans and Howard, there exists no book on the history of hospitals which does full justice to the subject in its entirety.

Data as recorded by one historian are often at variance with those of another, and in many instances asseverations are made without sufficient documentation, or are based on tenuous foundations. It may perhaps be a task which the Department of the History of Medicine at Johns Hopkins University, would consider as worth while to undertake. I have always regretted that the Section on Historical and Cultural Medicine of the Academy meets but four times in the year, as there are so many interesting old books and tracts which should be taken off the shelves and aired in seminar discussions to the benefit of all concerned.

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Historical research appeals to those of us who are interested in tracing the evolution of ideas and institutions, and who like to look backwards and appraise the efforts of the great minds of the past in evaluating the dimly discernible trends and tendencies of their own time and in moulding their environment. To me it has always been of very great interest to see how an apparently insignificant shoot is often destined to grow to full fruition, while something that to our limited understanding looks important and portentous, dwindles after a brief period of existence. Historical research quickens the imagination and often tempers such conceit as we may have about our own wisdom.

In the present essay I am not going back to the Babylonians and Egyptians, nor to ancient Greece and Rome; neither will I recite the interesting contributions of Islam nor remind you of the long and tortuous tale of the Middle Ages. I shall but attempt to delineate sketchily a few étapes in the evolution of the hospital idea in the United States from the time of Pasteur and Lister or thereabouts. It is only with the development of scientific medicine, as we know it today, that the hospital became what it is now, an institution for the care of the sick, and not an asylum or hospice for the lame, the weary, the cripples and the paupers. Here and there I will revert to the European prototypes of our present-day institutions.

Hospitals of the Past

It has been said that hospitals constitute one of the highly significant expressions of the state of civilization of a nation. If this be true, then civilization, characterized by the efficiency of its ways and the considerateness of its spirit, is of very recent origin.

With not very many exceptions, the hospitals of the past, although supposedly expressions of the charitable impulses of humankind, were loathsome institutions, breeders of infection, and as much feared by the sick as they were repugnant to the senses of sight and smell. Those who

have read John Howard's "Account of the Principal Lazarettos in Europe," 1785-86, or the descriptions of hospitals by Jacques René Tenon, or Florence Nightingale, or Jane Austen, or Charles Dickens and dozens of others, will appreciate that what I have just said is no exaggeration. Benjamin Rush called them "the sinks of human life," and in 1863 Dr. Charles Alfred Lee, of Albany, New York, made the following pessimistic remarks about the hospitals as he knew them: "It may be truly said that hospitals are in some measure the criteria of a nation's progress in civilization, and the measure of its cultivation of those charities which spring from the heart of a people imbued with philanthropic sentiments. And yet no institutions have been so abused and mismanaged as public hospitals. Originating in the purest benevolence, and supported with the most commendable liberalility, they have not only in a great measure failed in accomplishing the objects in view, viz., the recovery of the largest number of sick men in the shortest possible time, but they have even aggravated the very evils they were designed to remove. The laws of sanitary science, imperfectly understood, it is true, until comparatively modern times, have been, for the most part, disregarded and ignored by those who have had these institutions especially in charge, until at length it became a serious question whether it would not prove a blessing to mankind if they were not abolished altogether." And later yet Dr. W. Gill Wylie described in the following words the conditions as existed at Bellevue Hospital in New York in 1872: "At that time, with rare exceptions, the nurses were ignorant and in some cases worthless characters, who accepted the impossible task of attending to and nursing from 20 to 30 patients each. There were no night-nurses, the night-watchmen—three in number to a hospital of eight hundred beds—were expected to give assistance to patients requiring attention during the night. The hospital building, originally an old prison and almshouse erected sixty years ago, had been added to, and was now a massive stone structure with three stories and a basement. The wards were only separated from each other by the intervening

partitions inclosing the water-closets and bath-rooms, which were without ventilation, except as they opened into the wards. . . . The sanitary condition of the hospital was shocking. . . . I saw, while on duty in the wards, patients die from septic diseases contracted in the wards, after the slightest surgical operations or injuries. From forty to sixty per cent of all amputations of limbs proved fatal." The general mortality in the hospital was 14.7 deaths in every 100 patients, and 8.7 in every 100 women confined died of puerperal fever.

The Pavilion System

The first attempt to provide a plan for the building of hospitals in modern times was made by the French Academy of Sciences in 1788. It laid the foundations for the pavilion system of hospital construction which still survives in many places abroad and in some of the hospitals in this country. With a few features which peculiarly belonged to these hospitals, the pavilions could easily have been interchanged for barracks or prisons. In his Report on Barracks and Hospitals, published by the U. S. War Department in 1870, Dr. J. S. Billings refers to the recommendations of the French Academy as embodying the "true principles of hospital construction as at present understood." In view of the fact that this report of the French Academy dominated hospital thought for more than a century, it may be of interest to state in a few words what the principal recommendations were: A hospital should consist of isolated pavilions; each ward should be 24 feet wide, from 14 to 15 feet high, and 115 feet long, and it should contain from 34 to 36 beds; and the windows should extend to the ceiling. This new type of hospital plan, known as the 'pavilion' plan, was an improvement on the 'block' or 'corridor' plans of the former hospitals and at the time when Dr. Billings wrote it was still "recognized as the one best suited to its purpose, the experience gained during the late War having contributed greatly to the recognition of its value in this country."*

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The First American Contribution

What is probably the first outstanding contribution in the field of hospital construction in the United States is to be found in a treatise published in 1861 by Dr. John Green, Fellow of the Massachusetts Medical Society. In this treatise are embodied the prize plans which had been previously prepared by the author in answer to an advertisement of a Committee of the City Council of Boston. In the preface he says that "the plans are in no sense a copy of any building in the United States or Europe or elsewhere, but are believed to combine the most valuable features of the best hospitals in France, Great Britain, and Germany." It is verily a remarkable treatise. It deals with the general principles of location of hospitals; the need of tax maintained institutions; economies of construction and maintenance; relation of the hospital to teaching; heating and ventilation, and the kind of furniture best suited for a hospital. I shall dwell upon it a bit because to my knowledge, this treatise which embodies the most advanced hospital thought of the time is not as well known as it deserves to be. To begin with, the author points out the need of a central location of a hospital for acute diseases; it should be easy of access to patients, physicians and students, and the site should be selected with due regard for its cost, as well as the purity of air, and good drainage. He then proceeds to differentiate between patients acutely ill for whom a hospital within the city limits is needed and those who suffer from infirmities or chronic diseases, the convalescents and the insane for whom provision should be made outside of the city limits. He stresses the point that a hospital for convalescents in the country should be connected with and under the same general direction as the hospital of which it is a branch. In planning a hospital, future enlargement should be anticipated and the hospital should be so designed as to make such extension possible without undue expense. He refutes the then popular notion that a hospital is "a sanitary evil" to the neighborhood by pointing out that experience in the most crowded cities of Europe is sufficient evidence to the contrary. He

would protect, however, the neighborhood against unsightly and repulsive objects by erecting the hospital buildings around a central court, thus effectively cutting off the patients from the view of neighbors and passers-by. In designing buildings he stresses the importance of providing direct sunlight, which he recognizes as having beneficial influence on the sick, and suggests that the wards be so placed as to admit both the morning and afternoon rays. The few patients who suffer from diseases of the eye or of the nervous system should be accommodated in moderately dark rooms. To guard against the untoward influence upon the patients of the noise on the streets, particularly those who are not inured to it by a previous residence in the city, he suggests double windows. The ventilation is to be supplied through a complicated system of flues, vents, fireplaces, etc. Proper ventilation will guard against "hospitalism," by which was meant, the spread of infections which take place within the hospitals. He maintains that "epidemic diseases are not the necessary condition of the association of the sick, even in somewhat crowded wards." He refers to an institution, near Boston, where no epidemic has ever appeared, and "at all times wounds heal in its wards as promptly as in private practice in the most rural districts." This unusual condition in the particular hospital, he ascribes to the peculiarly exposed situation of the hospital buildings, which insures at all times the most thorough ventilation, and to "the absence at that hospital of all drains, water-closets, etc., either within or beneath the buildings." "These conditions," he adds, "can scarcely ever be realized in a city institution." To guard against overcrowding of the hospital and to insure its utilization by those who are acutely ill, he suggests the organization of out-patient departments, because of the extreme economy of this form of treatment; the opportunity it affords for "quick yet accurate diagnosis" and of "continuing the treatment of convalescents, who may thus be discharged from the wards much sooner than would otherwise be provident." Among the diseases which can be most successfully treated in this way he mentions venereal and

skin diseases, most of the ophthalmic and aural conditions, and a great variety of medical and surgical diseases which "though they do not confine the patient to his room are nevertheless productive of much suffering." He provides for a layout of the out-patient department consisting of two suites of rooms in the first story. Each suite includes a consultation room, an ante-room, and two waiting-rooms for the reception of patients of the two sexes. The consultation rooms are provided with seats for fifty students each, and have a circular arena, for the physician and patient, of sixteen feet in diameter. Provision is made for parlors for the visiting medical officers and house pupils and accommodation for students and visitors. There are waiting-rooms in connection with the drug dispensary. The hospital plan devised by Dr. Green in 1861 reflected his conception of a hospital which was as profound as it was new and original.

It recognized that "a proper classification of patients is of the highest importance." The separation of patients by sexes in the medical, surgical, and obstetrical departments is insufficient. Many of these classes should be subdivided. The contagious diseases should be treated separately. Venereal disease patients should not be in the same wards with "other surgical cases." The need of separating ophthalmic and neurological cases has already been mentioned. Single rooms are of invaluable aid in managing nervous patients who "may suffer intensely from the ordinary sounds of even a well regulated ward." He was the first to point out that some of the patients required separate rooms either for their own comfort or that of others, and suggested that every ward should have connected with it a room for the dying or delirious patients, and a part of the hospital with separate rooms should be set apart for the "foul" cases as well as for the noisy and unmanageable ones. He also recommended a few single rooms to be devoted to private patients—"strangers of means sufficient to defray the expenses of their sickness, but without home or friends in the city." He likewise advocated separate rooms for parturient women. In spite of the con-

siderable number of separate rooms which the plan provides, the great majority of patients are accommodated in common wards where they can be "more advantageously treated."

The wards should not accommodate more than 30 patients. A ward of this size can be well supervised by one head nurse "residing constantly in the ward or in an adjacent room," and two assistants for day and night service, besides other occasional help. A small kitchen or workroom, bathroom, and at least two water-closets should be attached to each ward. He provides the hospital with a bath-house for hot, cold, and vapor baths and a separate accommodation for sulphur, saline, and other medicated baths. In seaport towns he suggests the pumping of sea water directly from the harbor. The most convenient location for the bath-houses is near the laundry for the same fires and hydraulic apparatus may be used for both departments. The theater for post-mortem examinations forms an indispensable part of every well appointed hospital, an autopsy of every patient dying in the hospital should be made for the verification and correction of diagnosis. The rooms adjoining the autopsy room are to contain vaults for the reception of bodies and for the preparation of them for burial. The most appropriate place for a chapel in the hospital is within the court. The plan provides for an operating theater under the central cupola on the second floor which is entirely given over to surgical wards.

The dwelling houses for the medical director, resident physicians, superintendent, and interns; a lodge for the porter, living quarters for servants; a kitchen and dining rooms; store-rooms; are all provided for within the confines of the hospital.

One interesting reason given in support of a city hospital is that it affords greater freedom in the utilization of patients for study and research than is possible in an ordinary charitable hospital.

I do not know whether the Boston City Hospital, when it was built, incorporated all the features of the prize essay

above described, but irrespective of whether or not they followed all the suggestions made, it seems to me that it marks the beginning of the modern era in hospital thought.

The Sanitary Engineering Era

The next period in hospital evolution concerns itself with heating and ventilation, and the provision of special hospitals. The outstanding hospital writer of the period was Dr. John S. Billings whose general treatises on the subject of hospitals deal almost exclusively with the importance of proper air conditioning. The problem of ventilation constitutes a curious chapter in the history of hospitals and the pre-occupation with it has had a retarding influence on the appearance of the more modern and economical type of hospital building. It was because of the difficulties in providing proper mechanical ventilation that hospitals were not built over two stories in height. In the essay preceding the outline of the plans for the Johns Hopkins Hospital, Billings deals at length with the importance of ventilation in relation to "these particles known as disease germs, contagia, microzymes, micrococci, bioplasms, germinal matter, etc." He warns that these organisms resist the action of weak alkalis, such as soap and water, to a surprising degree; "indeed, in some cases they seem to gain new powers in the latter fluid which is not a desirable cleansing agent in a hospital. They are destroyed by a sufficiently high temperature or if moist by subjecting them to solution of sulphurous acid and ozone and by a number of other agents, known as disinfectants." It is because of the persistence of these germs in cracks and crevices that he recommends that only a part of the hospital be made into a permanent structure and the other parts should be in temporary tents and frame buildings which from time to time should be superseded by new temporary structures. "No system of diluting the air," he says, "of an hospital ward will give absolute security from the action of contagion, and we can therefore understand why it is that the usual mode of ventilation can never afford perfect security against the hospital diseases, not even if we double

the cubic space, and triple the air supply usually considered sufficient." In this association it may be of interest to recall that Florence Nightingale in her "Notes on Hospitals" written over two decades before, advocated natural ventilation by open windows and open fireplaces as the only efficient means for procuring fresh air. "What is all the luxury of magnificent windows for," she asks, "but to admit fresh air? To shut up your patients tight in artificially warmed air is to bake them in a slow oven. Open the Lariboisière windows, warm it with open fires, drain it properly, and it will be one of the finest hospitals in the world" (pg.16, 3rd ed.).

Pest-houses and Insane Asylums

Special hospitals or colonies for the victims of leprosy, plague, smallpox and other highly contagious diseases date back quite far into the past. The chief maritime cities maintained quarantine stations with which lazarettos were associated. Some of these lazarettos, as the one at Venice, for example, in many regards of arrangement and medical organization, would be considered modern even now, judging by the description of it in John Howard's treatise. The interests of commerce demanded the application of efficient methods in warding off the spread of epidemics, and the segregation and isolation of the sick incidental to the task were enforced with a ruthlessness consonant with the political and ethical concepts of the time. Even more tragic was the fate of the mentally deranged. They were the objects of derision and torture and were classed with idiots and criminals, kept in cages and jails, beaten and sometimes put to death as persons possessed by the demon. "The position of the madman under the old hospital system is one of the saddest pages in human history, and as the historian of Bethlehem Hospital (The 'Bedlam' Hospital), the Rev. E. G. O'Donoghue observes, 'his martyrdom did not cease till well into the 19th century'." In that hospital the patients were without clothing, for it was held that lunatics could feel neither heat nor cold; they were kept in semi-dark cells, six or more in the same room, chained

by the arm, neck, or leg to the walls, and "in spite of the revolting and agonizing sight these must have presented, Bedlam was one of the fashionable sights of London, whither the grand folk and the vulgar rabble could go on payment of the small sum of one penny admission fee, which went towards the revenue of the hospital, and gave them the right to tease the unfortunate inmates" (Evans and Howard, p. 103).

The Domain of Medicine Extends to the Insane

The first hospital department for the insane on this continent was established in connection with the Hôtel Dieu at Quebec in 1639. This was followed by a similar provision in 1752 at the Pennsylvania Hospital. The first hospital exclusively for the care of the insane was established at Williamsburg, Va., in 1773, and thus began the recognition of the fact that the psychoses belong within the domain of medicine. As is well known, the dawn of humane treatment in this realm is associated with the names of Pinel, in France; William Tuke and his son, Samuel, in England; and Benjamin Rush, in America. The kindly Rush pleaded that physicians should treat deranged patients with respect, but the treatment he advocated included such measures as privation of food, strapping to restraint chairs known as "tranquilizers," pouring cold water under the coat sleeves, subduing maniacs by withdrawals of as much as 20 to 40 ounces of blood or by keeping them "in a standing posture, and awake, for four and twenty hours."

The Bloomingdale Asylum, modeled after Tuke's "York Retreat" was opened "by the bounty of the Legislature of the State of New York" in connection with the New York Hospital in 1821. Its express design was "to carry into effect that system of management of the insane, happily termed moral treatment, the superior efficacy of which has been demonstrated in several of the hospitals of Europe. . . . This mild and humane mode of treatment . . . . may be considered as one of the noblest triumphs of pure and enlightened benevolence. But it is by no means the intention of the Governors to rely on moral, to the exclusion

of medical treatment. . . . Agriculture, horticulture and mechanical employments may be resorted to, whenever the inclination of the patient, or their probable beneficial effects may render them desirable. . . . Reading, writing, drawing, innocent sports, tending and feeding domestic animals, etc., will be encouraged as they may be found conducive to the recovery of patients. . . . The apartments of the house are adapted to the accommodation of the patients, according to their sex, degree of disease, habits of life, and wishes of their friends." The institution was located "about 7 miles from the City of New York near the Hudson River and facing the Bloomingdale Road," the spot where St. Luke's Hospital stands today.

With the evolution of psychiatry the old type of institution which was inherited from the monastic era, has been gradually modified. Thomas S. Kirkbride, of Philadelphia, who in 1854 published his treatise "On the Construction, Organization and General Arrangements of Hospitals for the Insane" is credited with the development of the improved type of hospital construction, although prior to him the "Association of Medical Superintendents of American Institutions for the Insane," which was organized in 1844, prepared "propositions" dealing with the building of hospitals. The propositions stressed the out-of-town location of hospitals for the insane, where ample pleasure grounds and gardens could be provided. The movement brought about an amelioration in the type of buildings and of sanitary surroundings. The Kirkbride plan consisted of the lateral type of buildings, of solid construction with the administration building in the center, and the wards in the wings. The more disturbed the patients were the further away were they accommodated from the administration building. As the hospitals grew in size and as both legislation and therapeutics demanded a better classification of patients, the old type of institution underwent changes. In some state hospitals the cottage plan construction was adopted.* In this connection it may

*For a more detailed account the reader is advised to consult Dr. George W. Henry's paper on "The Development of Hospital Care and Treatment

be of interest to mention that in Holland and Belgium the insane have been taken care of for centuries by the inhabitants of certain communes, such as Meer-en-Berg, in Holland, and Gheel in Belgium; these are the only countries in which the State has not assumed direct responsibility for the care of the mentally ill.

The Evolution of Specialties

Aside from the pest-houses and the insane asylums, the first special hospitals were those for eye diseases. This, at least, is true of London and Glasgow and Exeter, and New York. The Royal London Ophthalmic Hospital, known by its abbreviated title of "Moorfields" had its beginning in 1804 when the London Dispensary for the Relief of the Poor Afflicted with Eye Diseases was started. In 1805 Glasgow followed suit, and then Exeter in 1806. The first eye infirmary in New York was established in 1818 and three years later it was incorporated under the name of The New York Infirmary. Two years later a department for diseases of the ear was added. In 1856, after many peregrinations, the institution settled at its present site—Second Avenue and 13th Street. In time the hospitals for other specialties developed. In New York among the earliest special hospitals is the Woman's Hospital which is closely associated with the name of Dr. J. Marion Sims. Substantial grants were made by the City and the State toward the building of the institution. Then came the establishment of the Infirmary for Women and Children by the sisters Emily and Mary Blackwell in 1853. Richard Kershaw in his book on "Special Hospitals; Their Origin, Development and Relation to Medical Education," published in England in 1909, says that the "result of woman's enterprise in the hospital field is witnessed in many directions, notably in the establishment of institutions for the medical treatment of women by women." As the various specialties differentiated themselves from the main body of medicine and surgery, the demand for recognition ex-

of Mental Disease," published in the Proceedings of the First International Hospital Congress, held at Atlantic City, June, 1929.

pressed itself in the creation of special hospitals. Thus came into being hospitals for the diseases of the throat and nose; orthopedic conditions; diseases of childhood; tuberculosis; skin and cancer; neurology, and so forth.

The Preponderance of the Voluntary Effort

Barring the segregation of sufferers from pestilential diseases and from insanity, the state or the city did not consider the care of the sick as coming within the scope of its responsibility. Until comparatively recently the existence of institutions for the care of the sick was due almost in its entirety to individual benevolence or civic philanthropy.

It may be of interest to point out that with the exception of Bellevue Hospital and the City Hospital on Welfare Island, all of the hospital and out-patient development in New York, down to 1885, was due to private charity. In 1885 the Willard Parker Hospital was built as a city hospital, and three years later a site for another contagious disease hospital was bought by the then City of Brooklyn. This rather belated recognition on the part of the municipality toward the care of the sick poor holds true of all American cities. It was in keeping with British tradition and was in a measure due to the reluctance of entrusting the care of the sick to political governance. And yet it was at Bellevue Hospital that the first modern school for nurses was organized by a woman chosen for the task by Florence Nightingale, and it was at Bellevue that medical teaching led the way to further systematic organization. It was likewise in connection with Bellevue Hospital that the first ambulance service in the City was inaugurated for other than contagious disease cases. On the whole, however, it may be said that the voluntary, rather than the municipal, hospitals have been the pathfinders and leaders in the progressive evolution of the care of the sick, and in making the hospitals generally "safe for democracy." The building of pavilions for the

accommodation of pay patients in connection with the private charitable hospitals which was initiated in connection with St. Vincent's Hospital in New York, added, no doubt, to the prestige and raised the standards of these hospitals.

Out-Patient Clinics

Among the earliest medical institutions are the dispensaries. The New York Dispensary was established in 1791, the same year the New York Hospital was opened, to provide "assistance for that description of persons who, when deprived by the disease of the earnings of their daily labor, are also deprived of the means of procuring the medical assistance necessary for their relief." Many of the dispensaries had paid physicians who visited the sick poor in their homes. With the development of hospitals and the recognition of the importance of the interrelationship between the out-patient department and the hospital proper, came the enormous growth of the dispensary and the gradual subsidence to a vanishing point of domicilary treatment by hospital agents. In the last three decades the O.P.D. Clinic, or dispensary, assumed staggering proportions. In 1900 there were in the country 150 such institutions, and in 1932—eight thousand. The number of patients treated in the clinics of New York City alone reaches about two million at the present time.

The Modern Features of Hospital Organization

It would be difficult and presumptuous on my part to try either to trace or evaluate every one of the evolutionary phases in our hospital organization. It would be even more difficult to appraise the services of individuals who galvanized or inspirited the development. Just as in modern science generally, so in the present day complicated skein of hospital relationships, no new development comes in the *Deus ex machina* fashion. Whitehead in his "Science and the Modern World" pointed out that while Galileo's famous

experiment of dropping bodies of different weight from the Leaning Tower of Pisa could have been performed at any time during the preceding 5000 years, no discoveries in any of the modern sciences could have been made earlier than they were. The same applies to the development of the principal phenomena in the organization and functioning of the modern hospital. Bacteriology, histology, biochemistry, physics, and the other basic sciences are responsible for the existence of our hospital laboratories, and it is hard to assign their general incorporation within the hospital scheme to any one individual.

The improvement in the diagnosis and treatment of disease is likewise a collective achievement, although in so far as the change in medical teaching in the United States is concerned, recognition should be given to the work done by Dr. Abraham Flexner in his report on Medical Education published under the auspices of the Carnegie Foundation in 1910. He probably more than anyone else is responsible for the introduction of full-time professorships and for the subsequent change in the medical organization of our university hospitals. As long ago as 1877 Dr. W. Gill Wylie, to whose work I have already referred, said that "for more reasons than one, it is wrong for one physician to hold two or three hospital appointments at the same time. If he has a private practice to attend to besides preparing and delivering two or more lectures every week, it is utterly impossible for him to visit once every day his hospital patients and to do his duty toward them." Even to this very day this problem has not been adequately solved, although medical organization in our hospitals is on a much more satisfactory basis than it was two decades ago.

For the introduction of social service in hospitals we are no doubt indebted to Dr. Henry Dwight Chapin, of New York, and to Dr. Richard Cabot, of Boston. Dr. Cabot was also among the first in this century to stress the importance of proper organization of the out-patient department and in this connection the names of Dr. Charles N. B. Camac,

Dr. W. Gilman Thompson, and Dr. S. S. Goldwater should be mentioned.

To Miss M. Adelaide Nutting and Miss Annie W. Goodrich goes the credit for the development of our nurses' training schools and the good effect they had on raising hospital standards.

In the practical demonstration of the feasibility of a high type of institutional convalescence the name of Dr. Frederick Brush deserves recognition.

In the field of proper and scientific institutional care of patients suffering from chronic diseases the Robert Breck Brigham Hospital of Boston and the Montefiore Hospital of New York stand out most pre-eminently.

It is, however, very difficult to appraise individual contributions toward the great transformation which has taken place in the entire domain of organization, construction, and management of our hospitals. No doubt it was greatly influenced, on the one hand, by the growing appreciation on the part of the public of the importance of hospitals and the quickened sense of community responsibility for their proper maintenance and support, and, on the other hand, by the broader conception on the part of the medical profession of their responsibility to the community, the sick, and the advancement of medical science. The medical colleges and the scientific medical bodies, no doubt, had a large share in shaping the new outlook. The hospital administrators individually and through their associations, particularly the American Hospital Association which was established a little prior to the opening of the century, also exerted an enormous influence on the process of the transformation which has taken place. By going over the Transactions of the Annual Meetings of the American Hospital Association, one gets a picture of the number and complexity of the problems which were analyzed year after year, and decade after decade, by the administrators of hospitals and the outstanding leaders in the medical and nursing professions. In these discussions there reveals

itself the rise of the present day hospital idea. Among the men in that Association whose viewpoints and counsels prevailed may be mentioned Dr. George H. M. Rowe of the Boston City Hospital; Dr. C. Irving Fisher of the Presbyterian Hospital of New York; Dr. W. Gilman Thompson through whose influence more than that of any one individual the hospitals abandoned their former futile attempts at mechanical ventilation and came to a realization that small wards are more suitable than large ones to meet the different needs of various groups of patients; and Dr. S. S. Goldwater whose recognized executive gifts and whose ability judiciously to incorporate in the structural scheme the claims which each department of a hospital presents for due recognition, made him an outstanding figure in the hospital world.

In analyzing the influences which led to the improvement of our hospital work and organization a great measure of credit should be accorded to the American College of Surgeons and its standardization program. The State Boards of Social Welfare, the public health, civic and charity agencies helped to stimulate the hospital's recognition of its manifold community relationships and responsibilities.

Definition of the Modern Hospital Idea

If I were asked to describe briefly the concept of the modern hospital idea, and wherein it differs from the concepts of the past, I would say that it lies in the conscious effort which is being made to achieve the ultimate object, namely, the welfare of the patient, through a joint responsibility of all concerned. It is to this end that the present form organization of professional and executive staffs has been effected, the structural adaptation of the environmental facilities made and the interest of outside forces enlisted. It is the present day teamwork and all that has been done to render it possible that distinguishes the modern hospital from its predecessor of a generation ago. Toward this cooperative effort and joint responsibility all the forces within and without the hospital are being

brought into play. Hence the growing importance of the hospital in the community and its ever widening educational, civic, public health, and social welfare contacts and responsibilities.

Present-day Problems

Whether we have reached the ideal, I shall not attempt to say. On general principles, I suspect we have not. There are those who maintain that we have built our hospitals in too great units and that we have carried the size beyond the point of where the law of diminishing returns sets in. Some critics believe that the amount of space which our new hospitals devote to ancillary services is much too great in comparison with that allotted to the physical accommodation of the patients themselves. A recent calculation made by Mr. Edward F. Stevens, of Boston, the dean of the hospital architects in the United States, based on an analysis of a considerable number of hospitals of various types and sizes which were completed in the last few years in several cities, indicates that only 21 per cent of the available space is given over to actual accommodation for patients. Some maintain that our modern hospitals are too lavish in their appointments and extravagant in administration cost. Others point out that by building special hospitals or institutes, in connection with our stupendous medical centers, we are reverting to the 18th century idea of the pavilion system in a glorified form.

With the rest of the world, the hospital is now standing at the crossroads. The financial débâcle which has overtaken the world has temporarily suspended the building of new hospitals. The time, therefore, is particularly ripe to give very full consideration to the entire field as we see it today, and to appraise the evolution to date, with a view of directing it more consciously and more uniformly than has been the case up to a year or so ago. Have we overhospitalized ourselves, particularly in the cities? Have we gone too far in advising the public to resort to hospitals? Have we provided a sufficiently large number of institu-

tions for the care of the chronics and the convalescents? Has the integration of the dispensary with the hospital proceeded along the line of best medical thought? Are our hospitals making the most of their opportunities for the advancement of medical science and the improvement of general medical practice? Are we making available to the general public the facilities which the hospitals can give extra-murally? Has there been a sufficient linkage between the hospitals and the public health movement or preventive medicine? Are the hospitals and the out-patient clinics, free and pay, engaged in an unfair competitive relationship with the medical practitioners? Can the modern hospital organization make possible a larger participation in hospital work on the part of "family physicians?" Is the very recent idea of recruiting large groups of the population for the broadening of hospital support through the purchase of hospital service on an insurance basis going to exert a beneficial or harmful influence on the hospitals themselves? Have we gone too far or not far enough in providing hospital care through taxation?

These are but a few of the questions to which earnest thought must be given on the part of citizens of responsibility and of physicians interested in the evolution of social and medical ideals and institutions.

THE PSYCHIATRIC APPROACH OF THE PRACTITIONER TO HIS PATIENTS*

MORTIMER W. RAYNOR

Psychiatric problems are not new in the practice of medicine. It would seem though that mental illness is gradually becoming more prevalent and that now, more often than ever before, the practitioner has it to deal with. It may be true that there has been an increase in the incidence of psychiatric disorders as well as changes in their manifestations. This apparent increase, however, may be accounted for in various ways. Within comparatively re-

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